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EDITORIAL

Tailored integrated interventions for intimate partner violence and substance use are urgently needed

Around one in three women globally have experienced physical and/or sexual violence from a partner [1]. Intimate partner violence (IPV) includes any behaviour by an intimate partner causing physical, sexual or psychological harm, including aggression, sexual coercion, psychological abuse and controlling behaviours [1]. While some studies report that men and women report equal rates of IPV (i.e. 'gender symmetry') [2], women are more likely to experience controlling behaviours, sexual violence, to be injured or murdered by a partner than men [1,3]. Recent recognition of the harm from other forms of partner abuse including controlling and coercive behaviours, and the use of mobile technology to stalk and harass partners [4], has resulted in recent legislative changes in England and Wales to enable the prosecution of perpetrators of these types of behaviours. Additional forms of IPV described in recent research include mental health and substance use coercion, which is often used to undermine sanity or sobriety, control medication and treatment, sabotage recovery and access to resources and support [5].

Alcohol is involved in an estimated 23–65% of all domesic violence and is associated with fear, injuries, chronic mental and physical health problems and premature death among direct victims [1] and their children [6]. The prevalence of IPV victimisation and perpetration are higher among men and women in substance use treatment [7]. Many risk factors for IPV have been identified, including substance use, adverse childhood experiences, mental health problems, anger, sexist attitudes and support of gender-specific roles [8,9]. In their commentary in this issue, Leonard and Quigley [10] conclude that alcohol's contribution to IPV is 'approximately equal to other contributing causes such as gender roles, anger and marital functioning', and there remains ongoing debate about the direction of causation between IPV and substance use.

The association between IPV and substance use has significant implications for both substance use treatment and perpetrator programs. While there has been recent emphasis on the impact of alcohol-related family and domestic violence [11], limited evidence exists on how best to address and reduce such violence [12,13]. Moreover, there is disagreement surrounding whether it is safe to treat couples together, or whether to address substance use and domestic violence sequentially or in parallel. Promising results have been reported for integrated interventions that address domestic violence and substance use simaltaneously for both survivors and perpetrators [14,15].

This special issue provides commentaries, debate, reviews and primary research that contribute to our understanding of the role of alcohol and other drugs in intimate partner and dating violence, and desistance from violence; that identify the pathways to and factors associated with different types of IPV; and that offer solutions for responding to IPV among people who use substances. The series emphasises the urgent need for tailored integrated interventions to address different types of IPV among substance users.

While IPV is prevalent in all cultures and countries [1], cultures where norms that justify wife beating and male control of female behaviour are widely held report higher rates of IPV [16]. In this issue, Gilchrist *et al.* [17] compared the prevalence and risk factors for IPV perpetration among men in treatment for substance use in England and Brazil. They found that despite more gender-stereotyped attitudes towards women and gender roles in Brazil, similar rates of emotional IPV were reported across the two countries, higher rates of sexual IPV perpetration were reported in Brazil and higher rates of physical IPV perpetration were reported in England. These findings highlight the importance of exploring different types of IPV and tailoring responses. Gilchrist *et al.* [18] illustrate the importance of expectancies about the effects of alcohol in relation to IPV perpetration, consistent with previous work showing strong cultural expectancies that alcohol facilitates IPV [19]. There is also need to take into account adverse child events in interventions to address IPV perpetration, as two studies in this special issue highlight the association between IPV perpetration and trauma [20,21]. However, Madruga *et al.* [22] found that although witnessing parental violence was independently associated with being a victim of IPV, IPV perpetration was not associated with witnessing parental violence when experience of direct violence as a child was controlled for. Madruga found that the association between witnessing parental violence and being a victim of IPV

was mediated by depressive symptoms and by alcohol and cocaine use [22].

Two studies in this special issue show how mixed methods studies across different countries can help disentangle the nuances of the phenomenon of IPV. While the quantitative data from studies by Gilchrist *et al.* [17] and Watt *et al.* [21] suggested gender symmetry in the rates of IPV victimisation and perpetration experienced, their qualitative data provide a more nuanced contextual understanding, with instances of victimisation of women by male partners characterised as particularly frequent and intense. In a study of men in treatment for substance use in England and Brazil, Radcliffe *et al.* [23] found three types of narratives leading to IPV: (i) disputes centred on substance use; (ii) uncharacteristic loss of control as a result of alcohol; and (iii) perceived betrayal as a trigger. In narratives from South Africa, Watt *et al.* [21] found that IPV was explained by male aggression while using methamphetamine, norms around sex trading and gender-based attitudes endorsing violence against women. In another study featuring careful analyses of in-depth interviews with women who had experienced alcohol-related IPV, Wilson *et al.* [24] describe a 'cycle of escalating violence accompanying the male partner's progression from starting to drink (having fun) to getting drunk (looking for a fight); to intoxication ('switching' to escalated violence)'. Such in-depth understanding of the role of substance use in IPV from both survivor and perpetrator narratives is essential for informing integrated interventions.

Longitudinal data offer the possibility to consider the direction of the relationship between IPV and substance use. In this issue, Choi *et al.* [25] examine the link between alcohol and dating violence in teen relationships using latent transition analysis. They identify five separate latent statuses: (i) no violence, no alcohol consumption; (ii) alcohol consumption; (iii) psychological violence, no alcohol consumption; (iv) psychological violence, alcohol consumption; and (v) physical and psychological violence, alcohol consumption. This work establishes a platform for assessing the relationship between substance use and IPV over time, as well as exploring possible mediators, highlighting the importance of longitudinal studies.

Alcohol, cocaine and methamphetamine use are implicated in IPV perpetration [26–29]. Harms to others from an intimate partner's drinking are illustrated in a large cross-sectional and follow-up survey by Laslett *et al.* [30] in this issue. Findings with respect to cannabis are mixed [26,31,32]. Shorey *et al.* [33] investigate the relationship between cannabis and dating violence and conclude that methodological issues with the current evidence highlight the need for additional research in this area.

Leonard *et al.* [10], McMurran [34] and Crane and Easton [35] urge the field to move beyond these debates to develop integrated intervention responses to address both issues together to improve outcomes for victims and perpetrators alike. There remains a need for interventions to improve safety for survivors. In their novel trial presented in this issue, Gilbert *et al.* [36] report significant reductions in IPV victimisation and drug use for female substance users in Kyrgyzstan who received a brief intervention and referral to treatment (screening, brief intervention and referral to treatment) model (women initiating new goals of safety) with HIV counselling and testing. Placing such integrated interventions in a broader context such as Graham *et al.* [37] describe in their prevention model for alcohol-related IPV in the context of societal, community, relationship and individual risk factors and solutions is critical. We believe that individual or group interventions for substance users need to take into account different types and context of IPV [38–40], from situational couple violence where arguments can escalate into physical violence, to severe and escalating forms of violence characterised by multiple forms of abuse, terrorisation and threats and increasingly possessive and controlling behaviour on the part of the perpetrator (i.e. intimate terrorism) [41]. For example, Graham *et al.* [37] suggest that the perpetrator's loss of inhibitory control when consuming alcohol may be 'more important for situational violence than for intimate terrorism'. This nuancing of the types of violence and their relationship to substance use and the context surrounding an individual's experience could move the interventions for IPV field forward. For example, Gilchrist *et al.* [20] highlight the use of controlling behaviours and technology facilitated abuse in men receiving substance use treatment and the need to address this type of abuse in interventions. Other researchers in this special issue are starting to explore how problematic drinking and executive functioning deficits interact in relation to IPV perpetration [42], supporting the need for interventions that address adaptive emotion regulation skills. In a review of naturalistic studies, Murphy and Ting [43] found that reductions in IPV perpetration were associated with successful completion of substance use treatment. Little attention has been paid to the role of alcohol in desistance from IPV. Walker *et al.* [44] found that men who desisted from IPV had changed their attitudes towards alcohol and their use of it, which has important implications for treatment. While Wilson *et al.* [45] also reported reductions in both alcohol consumption and IPV perpetration following couples-based and individual alcohol treatment, in their more recent review, they concluded that study designs prevented attributing this association to treatment. Thus, more rigorous research is needed

'to examine whether changes in IPV over time are explained by concomitant changes in substance-abuse problems over the same period' [46].

Key priorities remain for IPV research. Current measurements of IPV have been criticised for limiting our understanding of gender patterns of IPV [47]. Further development of measurements that accurately identify and assess all types of IPV for both clinicians and researchers is required. Substance use treatment does not address IPV among substance users in 'a formal and comprehensive way', despite around 6 in 10 users having experienced or perpetrated IPV [48]. The lack of evidence about ways to effectively reduce IPV victimisation and perpetration among substance users and what might work for who is clear [12,13,49]. Development and testing of tailored integrated interventions that address both substance use and IPV for this client group is urgent.

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